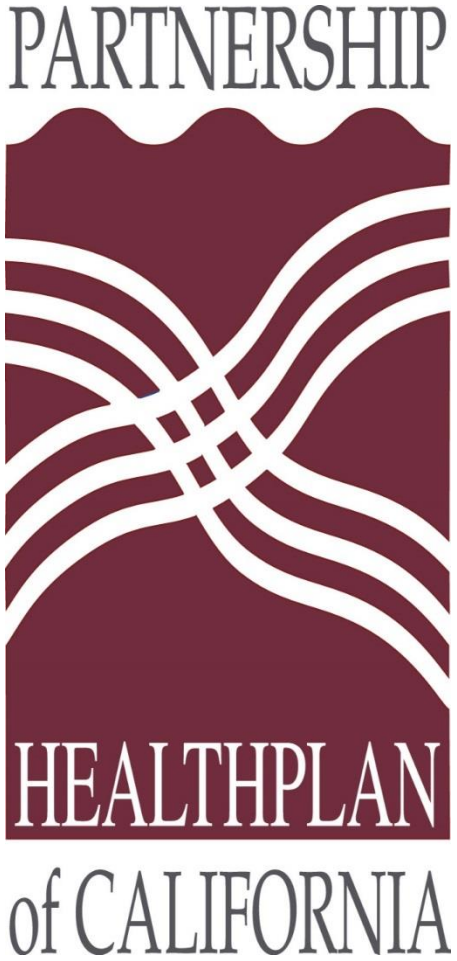

Health Homes and Long Term Support Services

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Partnership Health Plan and LTSS

PHC Covers:

- CBAS
- ICF
- SNF
- LTC

State Covers:

- IHSS

Self-pay and Federal:

- Residential Care for the Elderly (RCE)
- 30% have SSI and SSP support

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Partnership's Health Homes Program

Health Homes Program:

PHC's Intensive Out-Patient Care Management (IOPCM)

- IOPCM offers an additional layer of support
- Medically and socially complex members

Goals:

- Coordinate care
- Enhance social support
- Improve self management
- Reduce costs and utilization

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Partnership's Health Homes Program

Guidelines:

- Engagement
- Care Coordination
- Health Promotion
- Transitional Care
- Support Services

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Community Based Adult Services

- The health plan is financially responsible for CBAS services. A PHC RN case manager performs face to face visit, confirms diagnoses, and reviews the care plan.

- Patients: Alzheimer's, TBI, chronic disease with mental and physical components, cognitively challenged patients

- Services: transportation, physical and occupational therapy, RN evaluation, medication administration

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CBAS Opportunities

- **Challenges:**
  - CBAS sites are not the “medical home”
- **Opportunities:**
  - Integrating the daily care of these patients with their medical care and improving communication and outcomes
- **Recommendations:**
  - Develop systems to improve the real time communication with the medical home to improve coordination and integration of services.

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In Home Support Services

- IHSS is covered by the state, through local county administration.
- A County Social Worker determines medical necessity and hours of care that are needed, no direct role for health plan or provider.
- Services: housecleaning, meal preparation, personal care

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IHSS Opportunities

- **Challenges:**
  - The IHSS program is disconnected from the medical care services one receives. It is the decision of the consumer to inform their IHSS worker of medical issues and needs.

- **Opportunities:**
  - IHSS providers and consumers can be connected earlier and more efficiently to case management programs.

- **Recommendations:**
  - Engaging IHSS consumers and providers to be part of the Health Homes care team.
  - Invite the County to communicate with the Health Home team about members receiving services

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Goals for Health Homes and LTSS

- **Challenges:**
  - Fragmentation of funding
  - Lack of integration and communication between entities
- **Opportunities:**
  - Respond to the patient's needs
  - Coordinate services
  - Avoid fragmentation and silos of care
  - Improve continuity across medical, behavioral and LTSS services
- **Recommendation:**
  - Health home care management staff should connect with community providers and include them in multi-disciplinary care team meetings

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